STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Florida

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge			Amount and Basis for Determination
	Deduct.	Coins.	Copay.	
Hearing Services: The fitting and dispensing of hearing aids and the hearing aid device		X		Effective July 1, 1986, there is a five (5) percent coinsurance charge to recipient twenty-one years of age and older by hearing and dental service providers. Basis for the determination was the maximum charge offered in 42 CFR 447.54(a)(2)
Dental Service: Dentures and all services related to the provision of dentures		X		

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4. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

There is a copayment charge to recipients 21 years of age and older who are not pregnant, in Health Maintenance Organizations, in institutions, nursing homes, ICF/DDs, or receiving hospice care or family planning services. Providers are prohibited from denying services to recipients who are unable to pay their copayment. Basis for determination was the maximum allowable charges in 42 CFR 447.54 (a)(3) and 447.55(b).

Effective July 1, 1993, a $2.00 copayment applied to the following services:
Physician Services: New or established patient office/outpatient services, office/outpatient consultations, and general ophthalmological services.

Optometric Services: New or established patient office/outpatient services, and office/outpatient consultations.

Oral Surgeons: New or established patient office/outpatient services, and office/outpatient consultations.

Outpatient Hospital Services: Non-emergency services rendered in the emergency room.

Effective July 1, 1995, a copayment applies to the following services:
Inpatient Hospital: $3.00 copay per admission.

Outpatient Hospital: $3.00 copay per visit.

Rural Health Clinic: $3.00 copay per day per provider per recipient.

Federally Qualified Health Center: $3.00 copay per day per provider per recipient.

Osteopath, Physician, Physician Assistant, Nurse Practitioner, Podiatrist, or Optometrist: $2.00 copay per day per provider per recipient.

Home Health Agency: $2.00 copay per day per provider per recipient.

Community Mental Health: $2.00 copay per day per provider per recipient.

Independent Laboratory: $1.00 copay per day per provider per recipient.

Portable X-Ray Company: $1.00 copay per day per provider per recipient.

Chiropractic Services: $1.00 copay per day per provider per recipient.

Transportation: $1.00 copay per trip.

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B. The method used to collect cost sharing charges for medically needy individuals:

/X/ Providers are responsible for collecting the cost sharing charges from individuals.

/_/ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

Providers are required to ask for the copayment and must determine the recipient's ability to pay based on:

a) his response to the request for payment,
b) his past purchasing history with that provider,
c) his recent purchases of non-essential items.

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D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Due to the nature of the services subject to coinsurance, enforcement of the cost sharing exclusions is accomplished by simple MMIS edits flagging recipients who are:

1. Under 21 years of age,
2. Institutionalized,
3. Enrolled in HMOs,
4. Pregnant,
5. Receiving family planning drugs/supplies,
6. Receiving trial prescriptions of anti-arthritis drugs or anti-hyperlipidemics when required.

E. Cumulative maximums on charges:

/X/ State policy does not provide for cumulative maximums.

/_/ Cumulative maximums have been established as described below: